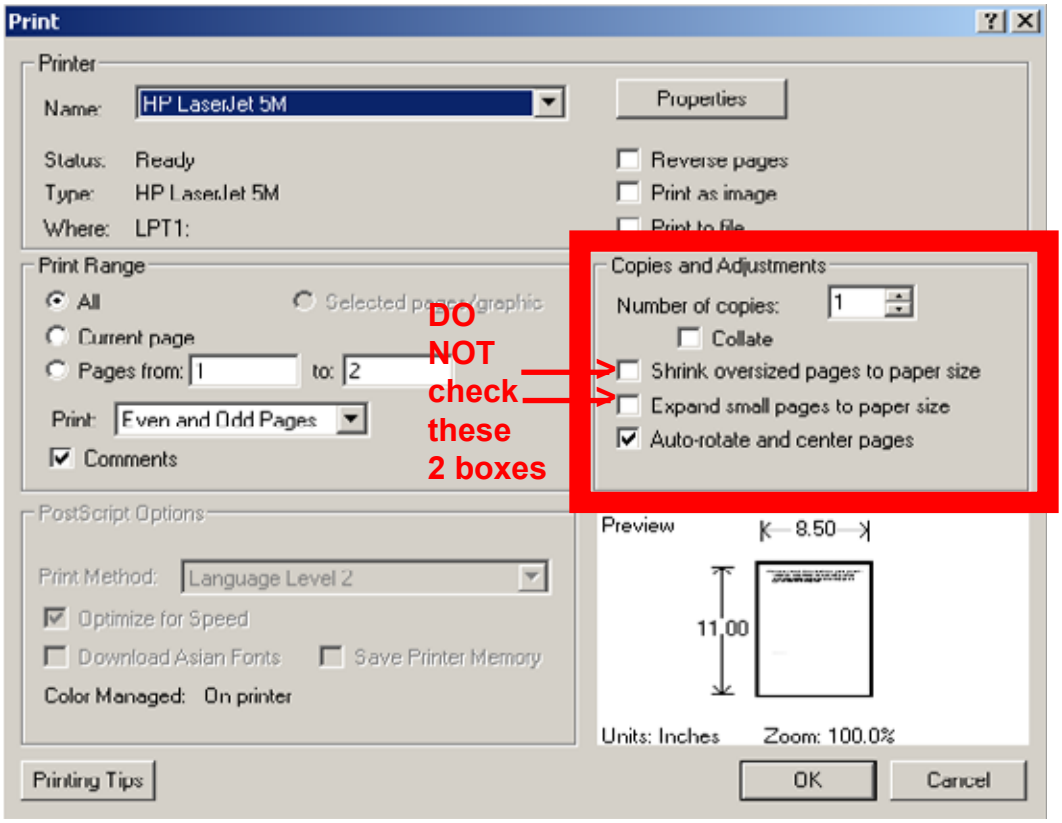
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box “Auto-rotate and center pages.” Do **not** check the Shrink or Expand boxes.



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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Expired Physician and Surgeon Credential Activation Application Packet (Expired Over Three Years)

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.

* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Physician and Surgeon (Expired Over 3 Yrs) DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 657-102 (REV 6/2006)

1F 0252090000 00236

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STATE OF WASHINGTON
DEPARTMENT OF HEALTH

Application Instructions for Physician and Surgeon Credential Activation (Expired Over 3 Years)

Attached is the abbreviated application packet for re-activation of your expired Washington State credential. When your application is received by the Department of Health, Medical Quality Assurance Commission, you will be sent an acknowledgment letter noting receipt. Program staff will create a pending file and add, as they are received, the incoming supporting documentation needed to complete the process. A deficiency letter will be sent to you approximately every four (4) weeks listing the outstanding documentation still needed to complete the abbreviated application process.

Please note: WAC 246-919-475(2) states "If the license has expired for over three years, the practitioner must: (a) Reapply for licensing under current requirements." Therefore in order to qualify for reissuance of your license, you must have completed two years of post graduate medical training in the United States or Canada (unless you graduated from medical school before July 28, 1985, then you would be required to have completed only one year of training).

To ensure that you have submitted the necessary fees, completed the appropriate sections of the application, and requested the required documentation, we encourage you to use the following checklist:

☐ Pay $630.00 in total fees. **(All fees are non-refundable)**

Application for Expired Physician and Surgeon Credential Activation

☐ ***Section 1: Demographic Information.***

Name: Please list your current name with middle initial.

Residential Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

Telephone Number: Enter current number where you may be reached during normal business hours.

Social Security Number: Required for license under 42 USC 666 and Chapter 26.23 RCW.

Additional Data: This information is required to update the Department's Database, and confirm information from your previous (initial) application.

☐ ***Section 2: Previous Credentialing.*** List ***all*** credentials you have held since last being credentialed in Washington State. List in chronological order, most current first. Include your last active credential in Washington State. If you need additional space, attach on a separate piece of paper.

☐ ***Section 3: Professional Experience.*** In chronological order, list all professional work experience since your Washington State credential has expired. Please identify all time breaks of 30 days or more. If you need additional space, attach on a separate piece of paper.

☐ ***Section 4: AIDS Education and Training Attestation.*** Required by WAC 246-12-040 and 246-919-380.

☐ ***Section 5: Criminal and Disciplinary Action Attestation.*** Required by WAC 246-12-040. This section pertains to formal or informal disciplinary action by any regulatory authorities, hospitals, state or federal jurisdictions, criminal convictions, and civil judgements connected with the practice of medicine. If you are unable to attest that you have not had action, please provide a synopsis of the situation, as well as the appropriate supporting documentation. **The Department does criminal background checks on all applicants.**

☐ ***Section 6: Continuing Education Attestation.*** Required by WAC 246-12-040 and 246-919-430.

☐ ***Section 7: Hospital Privileges.*** Please list in section 8 those hospitals where privileges have been granted in the past five years.

☐ ***Section 8: Applicant's Attestation.*** Required to be signed and dated in order to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Additional Documentation Required for Reactivation

☐ ***Professional Liability Action History Form.*** Malpractice information must include the nature of the case, date and summary of care given. The applicant must complete the Professional Liability Action History form for each malpractice case. Applicant must also include copies of the settlement or final disposition. If pending, indicate status. If the case is rather old, you should be able to contact the county where it was filed to get documentation. (Form provided)

☐ ***State Licensure Verification.*** Applicants must verify all medical licenses that he or she holds, or has held, in any other state, territory or possession of the United States or Canadian providence since the expiration date of your previous Washington State credential. Verification is required whether the license is active or inactive. This includes temporary and training licenses. Applicants should contact the state licensing authority for information regarding fees for verification of licensure. (Form provided)

☐ ***Hospital Privileges.*** Applicants must verify all hospitals where admitting or specialty privileges have been granted in the last five (5) years. Verification must be received directly from the hospital. All hospital privileges connected with military practice experiences may be verified by the current duty station or, if no longer in active service, the appropriate agency of record or National Personnel Records Center, (Military Personnel Records), 9700 Page Boulevard, St. Louis, MO 63132. (Form provided)

Federation of State Medical Boards Data Bank Clearance Report
AND
American Medical Association Physician Profile

These reports will be obtained be Department staff, however if staff is unable to obtain these reports electronically, the applicant will be require to submit requests and pay any applicable fees.

The process of reactivation will involve retrieval of your previous credential file from the state records center. The retrieval time period is approximately two (2) weeks.

Once the abbreviated application is considered complete, it will be referred for review, which will require approximately 14 days for processing a routine application for a final determination and 30 days for non-routine applications. All information, documents, data, etc., provided to the department by the applicant are to be submitted in writing and will become a part of the file. Telephone information will not be accepted in place of written documentation.

Upon approval of reissuance, your license will be activated from the approval date to your ***second*** birthday following that date. If, however, your first birthday after reactivation is within 90 days of issuance, your license will be issued to your third birthday. This license will be renewable every two years thereafter.

Applications and fees are to be sent to: DEPARTMENT OF HEALTH
Medical Quality Assurance Commission
P.O. Box 1099
Olympia, WA 98507-1099

All other inquiries and documents should be directed to: DEPARTMENT OF HEALTH
Medical Quality Assurance Commission
P.O. Box 47866
Olympia, WA 98507-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY
ISSUANCE DATE
LICENSE #

Credential #

Application For Expired Physician And Surgeon Credential Activation

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY | STATE | ZIP | COUNTY

NOTE: Your credentialing document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)

( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

— —

GENDER

☐ Female ☐ Male

BIRTHDATE (MONTH/DAY/YEAR)

/ /

PLACE OF BIRTH (CITY/STATE)

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list other name(s):

2. Previous Credentialing (Since Last Being Credentialed in Washington State)

STATE/JURISDICTION	PROFESSION	CREDENTIAL			METHOD OF CREDENTIALING	CURRENTLY IN FORCE
		TYPE	YEAR ISSUED	NUMBER		
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES
						☐ NO ☐ YES

3. Professional Experience (Since expiration of your Washington Sate credential _____)

NATURE OF EXPERIENCE OR PRACTICE AND LOCATION	DATES OF EXPERIENCE	
	FROM (MO/YR)	TO (MO/YR)

4. AIDS Education and Training Attestation

I certify I have completed the minimum of four (4) hours of education in the prevention, transmission and treatment of AIDS, which included the topics of etiology and epidemiology, testing and counseling, infection control guidelines, clinical manifestations and treatment, legal and ethical issues to include confidentiality, and psychosocial issues to include special population considerations. I understand I must maintain records documenting said education for two (2) years and be prepared to submit those records to the Department if requested. I understand that should I provide any false information, my license may be denied, or if issued, suspended or revoked.

APPLICANT'S INITIALS

5. Criminal and Disciplinary Action Attestation

I certify that no action has been taken by any state or federal jurisdiction or hospital, which would prevent or restrict my right to practice my profession.

I further certify that I have not voluntarily given up any credential or privilege or have not been restricted in the practice of my profession in lieu of or to avoid formal action.

APPLICANT'S INITIALS

The Department does criminal background checks on all applicants.

6. Continuing Education/Continuing Competency Attestation (If Applicable)

I certify that I have met all continuing education and competency requirements for the past two years. I am enclosing documentation on all courses attended/claimed.

APPLICANT'S INITIALS

7. Hospital Privileges

List hospitals in the U.S. or Canada where hospital privileges have been granted within the past five (5) years. (Attach additional 8 1/2 x 11 sheets if necessary.)

NAME OF HOSPITAL	BEGINNING (MO/YR)	ENDING (MO/YR)

8. Applicant's Attestation

I, _____, certify that I am the person described and identified in this
NAME OF APPLICANT

application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____
SIGNATURE OF APPLICANT

_____
DATE

Official Use Only

Washington State Records Center

Washington State Department of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

MD

Washington State Medical Quality Assurance Commission
Applicant's Professional Liability Action History

Applicant's Name: _____ Today's Date: _____

Please submit a ***separate form for each past or current professional liability claim or lawsuit*** which has been filed against you. (Photocopy this page as needed.) Only a legible and signed narrative which addresses all of the following details will be accepted.

1) Provide a detailed summary of the events of the case. Include the date of occurrence, your specific involvement, and the patient's clinical outcome. (Please submit additional pages of narrative if necessary.)

   Date of occurrence: _____ Details: _____

2) Date suit or claim was filed: _____ Name and address of Insurance Carrier that handled the claim: _____

3) Your status in the legal action (primary defendant, co-defendant, other): _____

4) Current status of suit or other action: _____

5) Date of settlement, judgment, or dismissal: _____

6) If the case was settled out-of-court, or with a judgment, settlement amount attributed to you, please disclose amount. **(You must enclose a copy of final disposition of case—this includes dismissals.)** $ _____

I verify the information contained in this form is correct and complete to the best of my knowledge:

_____ _____
SIGNATURE DATE

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Washington State Department of Health

MD

TO: State Medical Licensing

_____
NAME OF LICENSING AGENCY

_____
ADDRESS

_____

RE: Verification of License/Registration as a Physician

I am applying for a license to practice medicine as a physician and surgeon in the state of Washington and before my application can be reviewed, a verification of my licensure status in your state is required. I am authorizing the release of and would appreciate you providing the information and returning it, at your earliest convenience, **directly** to the address shown below. **Please note, all questions must be answered.**

_____ _____
APPLICANT (PRINT OR TYPE) BIRTHDATE

_____
SIGNATURE OF APPLICANT

This is verify that _____ was issued license

number _____ on _____ .

1. Date license, registration, or certification expires _____

2. Have any complaints been lodged against the license? ..... ☐ Yes ☐ No

3. Is there currently any investigation in process regarding the license? .....☐ Yes ☐ No

4. Has any disciplinary activity taken place regarding this license? .....☐ Yes ☐ No

If yes, please provide any information or documentation which may be released; i.e., charges and final disposition.

Return to:

Medical Quality Assurance Commission
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(SEAL)

Signature _____

Title _____

Hospital _____
PLEASE TYPE OR PRINT

Address _____

_____

Date _____

Telephone _____

(This page intentionally left blank.)

Washington State Department of Health

MD

TO: Hospital Administration

HOSPITAL NAME

ADDRESS

RE: Verification and Evaluation of Privileges

I am applying for a license to practice medicine in the state of Washington and before my application can be reviewed, a verification of my employment, with evaluations, is required. I am authorizing the release of and would appreciate you providing the information **directly** to the address shown below at your earliest convenience. **All questions must be answered.**

APPLICANT (PRINT OR TYPE) BIRTHDATE

SIGNATURE OF APPLICANT

1. _____ now has/has had admitting or speciality privileges at this hospital

from _____ to _____ .
BEGINNING DATE (MONTH & YEAR) ENDING DATE (MONTH & YEAR)

2. Have those privileges ever been restricted, suspended or revoked by the medical staff or administration?
☐ Yes ☐ No
If yes, please explain _____

3. Has the applicant ever been asked to resign? ☐ Yes ☐ No
If yes, please explain _____

Return to:

Medical Quality Assurance Commission
P O Box 47866
Olympia, WA 98504-7866
(360) 236-4785 (A-L)
(360) 236-4784 (M-Z)

(SEAL)

Signature _____

Title _____

Hospital _____

PLEASE TYPE OR PRINT

Address _____

Date _____

Telephone _____

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Overview and Summary of Physician Rules Governing Mandatory Continuing Medical Education

WAC 246-12-170 When is continued education required?

Continuing education is required for renewal of a credential only if authorized in law. The regulatory entity defines the continuing education requirements. Practitioners should refer to the laws and rules relating to their profession to determine if continuing education is required.

WAC 246-919-430 General Requirements. (1) Licensed physicians must complete two hundred hours of continuing education every four years as required in chapter 246-12 WAC, Part 7.

(2) In lieu of two hundred hours of continuing medical education the commission will accept a current physician's recognition award of the American Medical Association, or a current certificate from any specialty board approved by the American Board of Medical Specialties (AMBS) which is considered by the specialty board as equivalent to the two hundred hours of continuing medical education required under WAC 246-919-430(1). The commission will also accept certification or recertification by a specialty board as the equivalent of two hundred hours of continuing medical education. A list of the approved specialty boards are designated in the 1995 Official American Boards of Medical Specialty Director of Board Certified Medical Specialist and will be maintained by the commission. The list shall be made available upon request. The certification must be obtained in the four years preceding application for renewal.

WAC 246-919-450 Categories of creditable continuing medical education activities. The following are categories of creditable continuing medical education activities approved by the commission.

Category I—Continuing medical education activities with accredited sponsorship

Category II—Continuing medical education activities with nonaccredited sponsorship (maximum of 80 hours)

Category III—Teaching of physicians or allied health professionals (maximum of 80 hours)

Category IV—Books, papers, publications, exhibits (maximum of 80 hours)

Category V—Self-directed activities: Self-assessment, self-instruction, specialty board examination preparation, quality of care and/or utilization review (maximum of 80 hours)

WAC 246-919-460 Continuing medical education requirement. (1) The credits must be earned in the forty-eight month period preceding application for renewal of licensure.

(2) **Category I: Continuing medical education activities with accredited sponsorship.** The commission has approved the standards adopted by the Accreditation Council for Continuing Medical Education or its designated intrastate accrediting agency, the Washington State Medical Association, in accrediting organizations and institutions offering continuing medical education programs, and will accept attendance at such programs offered by organizations and institutions so recognized as Category I credit towards the licensee's continuing medical education requirement for annual renewal of licensure. The licensee may earn all two hundred credit hours in Category I.

(3) **Category II: Continuing medical education activities with nonaccredited sponsorship.** A maximum of eighty credit hours may be earned by attendance at continuing medical education programs that are not approved in accordance with the provisions of Category I.

(4) **Category III: Teaching of physicians or other allied health professionals.** A maximum of eighty credit hours may be earned for serving as an instructor of medical students, house staff, other physicians or allied health professionals from a hospital or institution with a formal training program if the hospital or institution has approved the instruction.

(6) **Category V: Self-directed activities.**

(a) A maximum of eighty credit hours may be earned under Category V.

(b) Self-assessment: Credit hours may be earned for completion of a multimedia medical education program.

(c) Self-instruction: Credit hours may be earned for the independent reading of scientific journals and books.

(d) Specialty board examination preparation: Credit hours may be earned for preparation for specialty board certification or recertification examinations.

(e) Quality care and/or utilization review: Credit hours may be earned for participation on a staff committee for quality of care and/or utilization review in a hospital or institution or government agency.

WAC 246-919-470 Approval not required. (1) It will be unnecessary for a physician to inquire into the prior approval of any continuing medical education. The commission will accept any continuing medical education that reasonably falls within these regulations and relies upon each individual physician's integrity in complying with this requirement.

(2) Continuing medical education program sponsors need not apply for nor expect to receive prior commission approval for a formal continuing medical education program. The continuing medical education category will depend solely upon the accredited status of the organization or institution. The number of creditable hours may be determined by counting the contact hours of instruction and rounding to the nearest quarter hour. The commission relies upon the integrity of program sponsors to present continuing medical education that constitutes a meritorious learning experience.

WAC 246-12-180 How to prove compliance. (1) If continuing education is required for renewal, the practitioner must verify compliance by submitting a signed declaration of compliance.

WAC 246-12-210 When is a practitioner exempt from continuing education? A practitioner may be excused from or granted an extension of continuing education requirements due to illness or other extenuating circumstances. The profession's regulatory entity determines when the requirements may be waived or may grant an extension.

WAC 246-12-220 How credit hours for continuing education courses are determined. A credit hour is defined as time actually spent in a course or other activities as determined by the regulatory entity as fulfilling continuing education requirements. A credit hour for time actually spent in a course can not be less than fifty minutes.

WAC 246-12-230 Carrying over of continuing education credits. Continuing education hours in excess of the required hours earned in a reporting period cannot be carried forward to the next reporting cycle.

WAC 246-12-240 Taking the same course more than once during reporting cycle. The same course taken more than once during the reporting cycle will only be counted once.

Commission Clarification

Certifications: Current certifications or recertifications by specialty boards may be used in lieu of 200 hours. The original certification may not be used more than once.

Waivers: Waiver requests are to be submitted with your renewal. The commission will not review any request unless it contains a detailed account of hours earned, and the reason for the request. The request should be submitted in sufficient time before the birthday to allow for processing time.

Residencies and Fellowships: These may be counted in Category I for 50 hours each year, up to 200 hours. A note should be made on the affidavit that the 200 hours are for a residency or fellowship. Fractional credits may be granted for years partially completed.

Category II: It is the responsibility of the physician to determine if his/her course work falls under Category I or II. Most hospitals are not CME accredited, so be sure to check with the hospital before reporting. Hospital staff meetings and specialty groups are some examples of Category II.

If all 200 hours being claimed have not been obtained in Category I, it is mandatory that the credit hours be earned in at least three categories. A maximum of eighty hours may be reported in each of the remaining four categories.

All fees should be directed to:

Department Of Health
Medical Quality Assurance Commission
PO Box 1099
Olympia, WA 98507-1099

All other inquiries or documents should be directed to:

Department Of Health
Medical Quality Assurance Commission
PO Box 47866
Olympia, WA 98504-7866

(360) 236-4785 (A-L)
(360) 236-4785 (M-Z)
(360) 236-4700 (Renewals at Customer Service Center)